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IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND,

Petitioner,

v.

HAWKEYE-SECURITY INSURANCE COMPANY,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTION PRESENTED

May a state statute authorize motor vehicle insurance companies and their insureds to subordinate motor vehicle no-fault benefits to benefits provided by a self-funded employee benefit plan in violation of the plan's terms, ERISA preemption of state law and ERISA's grant of exclusive authority to the plan's trustees to manage and control the plan's assets?

LIST OF PARTIES AND RULE 28.1 LIST

The parties to the proceedings below were the petitioner Central States, Southeast and Southwest Areas Health and Welfare Fund (the "Fund") and the respondent Hawkeye-Security Insurance Company ("Hawkeye").

The Fund is not a corporation.

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In The

Supreme Court of the United States

October Term, 1988

CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND,

Petitioner,

v.

HAWKEYE-SECURITY INSURANCE COMPANY,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

The Petitioner prays that a writ of *certiorari* issue to review a judgment and opinion of the United States Court of Appeals for the Sixth Circuit, which was entered on June 21, 1988.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Sixth Circuit is reprinted in the Appendix, p. 1d, *infra.*

The magistrate's report and recommendation, the order accepting magistrate's report and recommendation and the

order of judgment of the United States District Court for the Eastern District of Michigan (Newblatt, J.) are reprinted in the Appendix, pp. 1a, 1b and 1c, respectively, *infra*.

JURISDICTION

The judgment of the United States Court of Appeals for the Sixth Circuit was entered on June 21, 1988. The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

STATUTES INVOLVED

This case primarily involves Sections 514, 402, 403 and 404 of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. §§1144, 1102, 1103 and 1104 (1982), and Section 500.3109a of the Michigan No-Fault Insurance Act, Mich. Comp. Law Ann. §500.3109a. Citation is also made to Section 3(1) of ERISA, 29 U.S.C. §1002(1), Sections 500.3101 and 500.3107 of the Michigan No-Fault Insurance Act, Mich. Comp. Law Ann. §§500.3101 and 500.3107, and Section 500.2236 of the Michigan Insurance Code of 1956, Mich. Comp. Law Ann. §500.2236. These statutory provisions are reprinted in the Appendix, p. 1f, *infra*.

STATEMENT OF THE CASE

The Central States, Southeast and Southwest Areas Health and Welfare Fund (the "Fund") is an employee welfare benefit plan as described in Section 3(1) of ERISA, 29 U.S.C. §1002(1). The Fund self-funds all medical, hospital and disability benefits that it provides to participants and beneficiaries who reside in thirty-three states. (R.14: Stipulation of Facts at pp. 12, 13).

In the Fund's Plan Document ("Plan Document"), the Fund's Trustees establish rules of eligibility for receiving benefits, benefit levels, limitations on and exclusions from coverage and various terms and conditions applicable to benefits. As required by Section 404(a)(1)(D) of ERISA, 29 U.S.C. §1104(a)(1)(D), the Fund provides benefits to Fund participants and beneficiaries in accordance with the terms and conditions of the Plan Document.

Pursuant to their duty to utilize Fund assets prudently and to provide benefits on a uniform basis to all participants and beneficiaries, the Fund's Trustees have included a number of provisions in the Plan Document to avoid duplicate coverage and to ensure that specific risk insurers, such as motor vehicle no-fault insurers, do not attempt to transfer their responsibility for paying benefits to the Fund. Thus, the Plan Document provides for coordination of benefits ("COB") with different types of coverages. The Fund's COB provision provides that where no-fault or personal injury protection ("PIP") motor vehicle insurance coverage exists, the no-fault or PIP coverage shall be primarily responsible for providing benefits to a mutually covered beneficiary who has sustained injuries as a result of a motor vehicle accident and the Fund shall provide excess coverage. (R.14: Stipulation of Facts at p.

14). Specifically, Subsection 1.42(f) of the Plan Document identifies some of the "Other Plans" with which the Fund coordinates benefits:

> Automobile, motorcycle or other motor vehicle insurance coverage, issued in conformity with "no-fault" type or "personal injury protection" type laws or other similar state or local laws or regulations, which coverage provides benefits to or for a Covered Individual for bodily or psychological injury, including but not limited to: related hospital, surgical, dental and other medical expenses, which expenses are also covered by this Plan.

(*Id.*). Subsections 11.05(a), (b) and (c) of the Plan Document further provide:

> (a) An Other Plan, as defined in Section 1.42(f), shall have primary responsibility for providing benefits. The above designation of an Other Plan, as defined in Section 1.42(f), as primary shall prevail over any state or local law or regulation or provision in such Other Plan inconsistent therewith or contrary thereto.
>
> (b) In the event an Other Plan, as defined in Section 1.42(f), fails or refuses to assume primary responsibility for the payment of benefits, then, in order that the Covered Individual will not be disadvantaged by such failure or refusal, this Plan may provide the Covered Individual with the benefits as provided by other provisions of this Plan. Payment of benefits under this subsection by this Plan shall be under a reservation of rights and shall be without prejudice to this Plan's right to recover the amount of any such payments from the Other Plan.
>
> (c) Whenever payments have been made by this Plan pursuant to Section 11.05(b) which payments the Other Plan was required to make under Section 11.05(a) this Plan shall have the

> right to recover the amount of such payments from the Other Plan.

(*Id.*). Thus, where a Fund beneficiary is injured in a motor vehicle accident and has no-fault coverage, the Fund will coordinate its benefits with benefits under the no-fault coverage and pay benefits on an excess basis.

In the State of Michigan, car owners are required to purchase motor vehicle no-fault insurance or deposit a security payment with the secretary of state, and motor vehicle insurance companies are required to offer motor vehicle no-fault insurance coverage and to pay medical benefits for injuries sustained in motor vehicle accidents. Mich. Comp. Law Ann. §§500.3101(1), 500.3107(a). With certain exceptions not applicable to this case, the Commissioner of the Michigan Department of Insurance must approve all provisions of insurance policies, which are approved by virtue of their authorization by state statutes, insurance regulations or special application to the department of insurance. *See* Mich. Comp. Law Ann. §500.2236(1), (6). One provision mandated by the Michigan No-Fault Insurance Act is a COB provision which would transfer primary responsibility for providing benefits for injuries sustained in motor vehicle accidents from the motor vehicle no-fault insurer to other health and accident coverage possessed by the injured party. *See* Mich. Comp. Law Ann. §500.3109a. Section 500.3109a provides in pertinent part:

> An insurer providing personal protection [motor vehicle] insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The deductibles and exclusions required to be offered by this section shall be subject to prior approval by the commissioner and shall apply only to benefits payable to the person named in the

> policy, the spouse of the insured and any relative of either domiciled in the same household.

Id. In construing Section 500.3109a, the Michigan courts have held that where the motor vehicle no-fault insurer has issued a COB provision based upon Section 500.3109a and the other health and accident insurance coverage has a COB provision making no-fault insurance primarily responsible for the payment of benefits to a mutually insured party, the no-fault insurer's provision must be enforced, thus making the health and accident insurance coverage prime. *See Federal Kemper Ins. Co. v. Health Ins. Admin., Inc.*, 424 Mich. 537, 383 N.W.2d 590 (1986).

On or about August 1, 1984, Fund participant Todd A. Cannon, his spouse Priscilla and children, Nicholas and Chad, were injured in a motor vehicle accident which necessitated hospital and medical treatment. Upon notice that respondent provided no-fault coverage to Todd A. Cannon and his family, the Fund assumed secondary responsibility for the payment of benefits pursuant to its COB provision. Respondent's claims representative and legal counsel acknowledged and respondent assumed primary responsibility for the payment of benefits.

Respondent subsequently reversed its position and filed a declaratory judgment action pursuant to Section 500.3109a in the circuit court for the County of Genesee, Michigan, seeking reimbursement of benefits in excess of $25,000.00 from the Fund. The Fund removed this action to the United States District Court for the Eastern District of Michigan, Southern Division, pursuant to 28 U.S.C. §1441(a) on the basis of diversity citizenship between the respondent and the trustees of the Fund as specified in 28 U.S.C. §1332(a)(1) and the federal question basis, regarding ERISA preemption raised pursuant to Section 514 of ERISA, as provided in 28 U.S.C. §1331.

Respondent admitted that pertinent provisions of its insurance policy are based upon Section 500.3109a of the Michigan No-Fault Insurance Act:

> . . . the relevant provisions of the Hawkeye-Security Insurance Company automobile liability insurance policy provides for coordination with other health and accident coverage on the insured, pursuant to MCLA 500.3109(a) of the Michigan No-Fault Statute. . . .

(R. 14: Stipulation of Facts at p. 11). The coordination provisions of appellant's policy, in pertinent part, provide:

> PERSONAL PROTECTION INJURY COVERAGE—MICHIGAN ENDORSEMENT A166A:
>
> The following options apply as indicated on Declarations—
>
> Coordination of benefits:
>
> Coordination of medical expenses applies to you or any family member.
>
> Coordination of work loss benefits applies to you or any family member.
>
> Deductible:
>
> A deductible applies to you or any family member.

(*Id.*).

The parties filed cross-motions for summary judgment, and after the issues had been fully briefed and oral argument had been heard, United States Magistrate Marc L. Goldman issued his report and recommendation that the Fund's motion for summary judgment be granted and respondent's motion be denied. (Appendix, p. 1a, *infra.*). Following this Court's decision in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), the Magistrate found that Section 500.3109a was an attempt by the State of Michigan to regulate a self-funded employee benefit plan by requiring it ". . . to assume primary responsibility

for payment of medical benefits for injuries arising out of an automobile accident, in contravention of its own terms. . . ." (Appendix, p. 5a, *infra.*). The Magistrate stated such state regulation of a self-funded employee benefit plan was preempted by Section 514 of ERISA, 29 U.S.C. §1144. (*Id.* at 7a). Thereafter, United States District Court Judge Stewart A. Newblatt entered an order accepting the magistrate's report and recommendation and entered judgment for the Fund. (Appendix, pp. 1b and 1c, respectively, *infra.*).

The respondent appealed, and the United States Court of Appeals for the Sixth Circuit reversed the district court on the basis of its decision in the factually analogous case of *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, ____ U.S. ____, 108 S.Ct. 1754 (1988) (Appendix, p. 1d, *infra.*). In *Northern Group*, the Sixth Circuit held that Section 500.3109a was not preempted by ERISA because of the priority of the state's power to regulate insurance. 833 F.2d at 94-95. In *Northern Group*, the Sixth Circuit acknowledged that its analysis may be inconsistent with this Court's decision in *Metropolitan Life* but labelled as *dicta* this Court's ruling that self-funded employee benefit plans are not subject to direct or indirect state regulation. *Id.* at 94.

THE REASONS FOR GRANTING THE WRIT

I.

REVIEW IS NECESSARY TO RESOLVE THE CONFLICT BETWEEN THE DECISIONS OF THIS COURT AND THOSE OF THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT WHICH DECISIONS SEVERELY LIMIT THE SCOPE OF ERISA PREEMPTION OF STATE LAW REGULATION OF SELF-FUNDED EMPLOYEE BENEFIT PLANS

The Sixth Circuit's decisions in the instant case and the *Northern Group* case directly conflict with the plain meaning and legislative history of Section 514 and other substantive provisions of ERISA and with several of this Court's decisions which construe Section 514 of ERISA. In both cases, the Sixth Circuit devised a new test for ERISA preemption, requiring that, if a self-funded employee benefit plan is to avoid state regulation, it must first demonstrate a federal interest in national uniformity *independent of and beyond* the requirements of Section 514 of ERISA, and that this specific federal interest must then ". . . outweigh the McCarran-Ferguson interest in state regulation of insurance." *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85, 95 (6th Cir. 1987), *cert. denied*, ____ U.S. ____, 108 S.Ct. 1754 (1988). To justify adoption of this "balancing test," which subordinates Congress' goal to establish uniform, comprehensive federal regulation of employee benefit plans to the states' power to regulate insurance, the Sixth Circuit advanced an unsupportable interpretation of the deemer clause in Section 514, discovered the existence of an unidentified ambiguity in the legislative history of Section 514 and skirted a prior ruling by this Court on the premise that the insured-uninsured distinction between

employee benefit plans is nothing more than *dicta*. *Id.* at 91-95. In charting this course, the Sixth Circuit has disregarded the facts that the conflicts between the Michigan No-Fault Insurance Act and ERISA will undermine the plan fiduciaries' exclusive authority to control and manage plan assets by allowing Fund beneficiaries in Michigan to increase the Fund's benefit costs to the financial detriment of beneficiaries in thirty-two other states and may spawn multi-state litigation as this "balancing test" is applied to present and future state laws affecting ERISA-covered employee benefit plans.

A. The Sixth Circuit's Decisions

An examination of the Sixth Circuit's opinion in this case and *Northern Group* establishes that it has disregarded this Court's interpretation of Section 514 of ERISA and has decided to introduce an additional test for ERISA preemption that will allow states to regulate self-funded employee benefit plans in all matters covered by state insurance laws. The Sixth Circuit has premised its restrictive interpretation of the deemer clause in Section 514(b)(2)(B) upon Sections 514(b)(2)(A) and 514(d), which exclude state insurance laws and regulations from ERISA preemption. *Id.* at 91-92. As additional support for its restrictive interpretation of the deemer clause, the Sixth Circuit has determined that the scope of ERISA preemption intended by Congress is expressed in a very general way and that the legislative history concerning the deemer clause is ambiguous. *Id.* at 89, 92. Ignoring much of the legislative history of Section 514 discussed at length by this Court, the Sixth Circuit concluded that Congress' main concern in adopting such a broad preemption provision was to avoid "intentional and perhaps pretextual" attempts by states to restrict ERISA plans from performing functions permitted by federal law. *Id.* at 93.

In addressing the preemption scope explained by this Court in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), the Sixth Circuit acknowledged that its analysis may be inconsistent with *Metropolitan Life* but disregarded as mere *dicta* this Court's ruling that self-funded employee benefit plans are not subject to direct or indirect state regulation. 833 F.2d at 94. In a footnote, the Sixth Circuit explained that its attempt to "reconcile" the savings and deemer clauses is supported by this Court's decision in *Pilot Life Ins. Co. v. Dedeaux*, ____ U.S. ____, 95 L.Ed. 2d 39, 107 S.Ct. 1549 (1987), in which this Court, according to the Sixth Circuit, expanded the analysis on the scope of the savings clause. *Id.* at 94 n.6.

In its analysis of the relationship between the savings and deemer clauses, the Sixth Circuit began with the presumption that Congress intended that benefit obligations of employee benefit plans are to be ". . . governed by a rational system of state law and federal common law." *Id.* at 89. After having found that the Michigan law at issue, i.e., Mich. Comp. Law Ann. §500.3109a, "relates to" self-funded employee benefit plans because it requires such plans to assume primary responsibility for payment of benefits excluded by plan documents, the Sixth Circuit also discovered that "[n]either the principal purpose nor the main effect of the Michigan coordination of benefits law is to restrict the range of options open to ERISA plans." *Id.* at 93. In the view of the Sixth Circuit, unless a state insurance law is shown specifically to regulate the content of welfare benefits provided by an ERISA-covered plan, the Sixth Circuit's balancing test must be applied. *Id.* at 93. The Court rejected the axiom that uniform federal regulation of self-funded employee benefit plans is the ERISA preemption goal because deference "willy nilly" to such an "arbitrary system" would allow trustees

of employee benefit plans to ". . . decide every issue in their own favor without judicial review." *Id.* at 94.

Despite the statutory language of ERISA and Congress' direction that federal common law should be developed by the federal courts to fill in gaps resulting from ERISA's broad preemption of state law, the Sixth Circuit concluded that the courts should defer to state insurance law instead of developing federal common law under ERISA to avoid overlaps and conflicts between federal and state law. *Id.* In the case at bar and *Northern Group*, the Sixth Circuit has in effect determined that the state's interest in authorizing residents to purchase motor vehicle insurance at lower premiums by designating their ERISA plan coverage as prime outweighed the disruption of the comprehensive ERISA regulation scheme established by Congress.

B. This Court's Decisions

In several decisions, this Court has affirmed both the plain meaning and legislative history of Section 514 of ERISA by holding that ERISA's comprehensive preemption of state law was meant to minimize state interference with administration of employee benefit plans so that such plans would not have to be administered differently in each state in which they operate. *See, e.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983); *Fort Halifax Packing Co., Inc. v. Coyne*, ____ U.S. ____, 96 L.Ed. 2d 1, 107 S.Ct. 2211, 2217 (1987). Nearly every aspect of the Sixth Circuit's analysis of the deemer clause and its relationship to the savings clause, however, is in conflict with this Court's decisions.

As to the plain meaning of the deemer clause, this Court has held that it is unambiguous: "The deemer clause makes clear that a state law that 'purport[s] to regulate

insurance' cannot deem an employee benefit plan to be an insurance company." *Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. at 1552. Thus, the deemer clause is the specified exception to the savings clause, which preserves state insurance and other laws from ERISA preemption, and the deemer clause prohibits employee benefit plans from being regulated by ". . . any law of any State purporting to regulate insurance companies, insurance contracts. . . ." 29 U.S.C. §1144(b)(2)(B). *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 733. Finally, this Court has emphasized that in construing Section 514 of ERISA the plain language must be enforced unless there is good reason to believe Congress intended a more restrictive meaning to apply.[1] *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 97. Therefore, the Sixth Circuit's narrow construction of the deemer clause in Section 514 is in conflict with principles this Court has recognized and expressed.

In reviewing the legislative history of Section 514, this Court has quoted from statements of ERISA sponsors that ERISA preemption is purposely broad in scope to protect ERISA-covered plans from a need to comply with conflicting and inconsistent state laws. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 107 S.Ct. at 1552; *Shaw v. Delta*

[1] It should be noted that Congress has considered the issue of coordination of benefit rules adopted by self-funded employee benefit plans and amended Section 514 of ERISA in 1986 to prohibit such plans from enforcing plan provisions that would make them excess coverage to medicaid. 29 U.S.C. §1144(b)(8). *See also Wisconsin Dep't of Health and Social Services v. Upholsterers Int'l Union Health and Welfare Fund*, 686 F. Supp. 708, 714-716 (W.D. Wis. 1988). This limited amendment is but further evidence that a judicially-created exemption to ERISA preemption allowing the state of Michigan to rewrite the coordination provisions of self-funded ERISA plans cannot be justified under the statutory framework of Section 514.

Air Lines, Inc., 463 U.S. at 98-100. Indeed, Congress considered and rejected bills which allowed preemption of only subject matters expressly governed by ERISA and which did not include a deemer clause reserving regulation of ERISA plans to the federal government. 463 U.S. at 98. These bills were rejected not only because they would have required ERISA plans to comply with multiple and potentially conflicting state laws but also because they raised the possibility of "endless litigation" on issues of whether state regulation impinged upon federal regulation. *Id.* at 99 n.20. Moreover, after a period of monitoring by the Congressional Pension Task Force and hearings by a House Subcommittee, a report evaluating ERISA's preemption provisions was issued, and it stated: "the Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded." *Id.* at 100 n.20, *quoting*, H.R. Rep. No. 94-1785, p. 47 (1977).

This Court has repeatedly affirmed the broad preemptive scope of ERISA and prohibition against even indirect state action bearing on self-funded employee benefit plans. *See, e.g., Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 739, 747. In the *Metropolitan Life* case, this Court explained that it is merely enforcing Congress' mandate that self-funded employee benefit plans not be subjected to indirect state regulation:

> We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter.

471 U.S. at 747 (footnote citation omitted). This Court has also rejected attempts to limit ERISA preemption to those laws which "specifically" regulate self-funded plans. *See, e.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 98.

Moreover, the Sixth Circuit's reliance upon the *Pilot Life* case as a justification to deviate from the plain meaning and legislative history of Section 514 of ERISA is erroneous. In *Pilot Life*, this Court went beyond the preemption analysis utilized in *Metropolitan Life* in construing Section 514 of ERISA because the issue in *Pilot Life* concerned preemption of a state law which conflicted with a substantive provision of ERISA. 107 S.Ct. at 1558. Accordingly, this Court examined the language and legislative history of the substantive ERISA provision. *Id.* at 1555-1558. On the contrary, the Sixth Circuit, while not suggesting any conflict with a substantive ERISA provision, engaged in an in-depth consideration of the state policies underlying Section 500.3109a of the Michigan No-Fault Insurance Act and concluded that the state's power to regulate insurance must be given primacy over Congress' intention that regulation of self-funded ERISA plans remain an exclusively federal concern.

Ironically, the state law that the Sixth Circuit has enforced against self-funded employee benefit plans does conflict with substantive provisions of ERISA. Section 500.3109a of the Michigan No-Fault Insurance Act is a delegation of authority by the State of Michigan to motor vehicle no-fault insurance companies and their insureds to increase benefit costs of self-funded employee benefit plans in contravention of plan documents. By requiring no-fault insurers to offer a lower-priced premium on the condition that the insureds designate their health coverage as primarily responsible for providing benefits for injuries sustained in motor vehicle accidents, the State of Michigan

is authorizing these parties to dictate to self-funded, ERISA-covered employee benefit plans when they must pay benefits and what amount of benefits they must pay. Such control over plan assets is a usurpation of the plan trustees' exclusive authority and duties under ERISA to control and manage plan assets in the best interest of all participants and beneficiaries. *See* 29 U.S.C. §1102(a)(1) (the plan must be administered pursuant to a written instrument and named plan fiduciaries have authority ". . . to control and manage the operation and administration of the plan."); 29 U.S.C. §1103(a) (". . . the trustee or trustees shall have exclusive authority and discretion to manage and control the assets of the plan. . ." except for certain circumstances not applicable to this case); 29 U.S.C. §1104(a)(1)(D) (plan fiduciaries are required to perform their duties solely in the interest of all participants and beneficiaries in accordance with the provisions of the plan document). Under the *Pilot Life* analysis, the Sixth Circuit was obliged to review the legislative history of these ERISA provisions, and the only reasonable conclusion of such a review is that Congress intended plan fiduciaries to exercise exclusive authority and responsibility to determine benefit amounts, costs and conditions.

C. The Consequences Of The Conflict Between This Court's And The Sixth Circuit's Decisions On ERISA Preemption

If the Sixth Circuit's decisions on ERISA preemption are left standing, the adverse effects will be drastic for the courts and for self-funded employee benefit plans and their participants and beneficiaries. As to the lower courts, they will be forced to resolve the serious conflicts between this Court's and the Sixth Circuit's decisions. Because the balancing test advanced by the Sixth Circuit

encourages challenges to ERISA preemption, the limited resources of the courts will be diverted to a multitude of lawsuits to determine how far ERISA preemption has been, and can be, eroded.

Self-funded employee benefit plans, including the Fund, will be faced with serious administrative and financial burdens. To the extent their exclusive authority to manage and control plan assets will be subordinate to state insurance law, plan fiduciaries will be forced to abide by Michigan beneficiaries' decisions about when accident-related benefits must be paid by the ERISA plan. To that same extent, the contributions made to the Fund on behalf of the Fund's participants in thirty-two other states will be used to subsidize the lower motor vehicle insurance premiums offered to Michigan beneficiaries. As this Court foretold in the *Fort Halifax* opinion, subjecting self-funded ERISA plans to differing state laws will disrupt their current uniform administrative systems. 107 S.Ct. at 2216. If this is to occur, the Fund may be compelled to ascertain and comply with insurance laws of thirty-three states possibly applicable to the Fund in light of the Sixth Circuit's balancing test. Because the states have different and inconsistent insurance laws, the Fund may need to expend considerable plan assets to achieve such compliance. Other financial burdens will also result. Subsidizing the motor vehicle premiums of Michigan beneficiaries was not an anticipated benefit cost of the Fund and, to do so, the Fund must suffer a substantial drain on its assets. The Fund will also be faced with additional litigation costs because the Sixth Circuit's decisions create uncertainty in the law and will undoubtedly spawn even more litigation.

II.

REVIEW IS NECESSARY TO RESOLVE THE CONFLICT BETWEEN THE UNITED STATES COURTS OF APPEAL FOR THE SIXTH AND SEVENTH CIRCUITS ON THE QUESTION WHETHER ERISA PREEMPTS SECTION 500.3109a OF THE MICHIGAN NO-FAULT INSURANCE ACT

The United States Courts of Appeal for the Sixth and Seventh Circuits have issued decisions applying Section 500.3109a of the Michigan No-Fault Insurance Act which conflict on the questions whether this statute is preempted by ERISA and in what manner responsibility for providing benefits should be divided between ERISA plans and motor vehicle no-fault insurers.[2] *See Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987); *Hawkeye-Security Ins. Co. v. Teamsters Central States Health and Welfare Fund*, App. No. 87-1201, slip op. (6th Cir. June 21, 1988) (Appendix, p. 1d, *infra.*); *Winstead v. Indiana Ins. Co.*, App. No. 87-2437, slip op. (7th Cir. August 22, 1988) (Appendix, p. 1e, *infra.*). In considering the identical legal issues raised by the same self-funded employee benefit plan as the appellant in the case at bar, the Fund, the Seventh Circuit held that Sec-

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[2] The decisions of the Sixth Circuit also conflict with decisions issued by the Courts of Appeal for the Third, Fifth and Ninth Circuits which followed this Court's analysis in *Metropolitan Life* in reaching their rulings. *See Insurance Bd. Under Social Ins. Plan of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408 (3rd Cir. 1987) (state mandated-benefit law cannot be enforced against a self-funded employee benefit plan due to ERISA preemption); *Childrens' Hosp. v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985) (state mandated-benefit law cannot be enforced against a self-funded employee benefit plan due to ERISA preemption); *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986) (state anti-subrogation law is preempted as to self-funded employee benefit plans).

tion 500.3109a is not preempted by ERISA because it does not "relate to" an ERISA plan and that the ERISA plan and the motor vehicle no-fault insurers must share responsibility for providing benefits on a *pro rata* basis. (Appendix, pp. 5e, 7e-9e, *infra.*). In contrast, the Sixth Circuit held that Section 500.3109a clearly related to self-funded employee benefit plans and is within the scope of the general preemption clause of Section 514a of ERISA but ruled that it was saved by preemption by application of the Sixth Circuit's balancing test. 833 F.2d at 88-94. In addition, the Sixth Circuit rejected *pro rata* division of responsibility for providing benefits in light of the Michigan Supreme Court's decision in *Federal Kemper Ins. Co. v. Health Ins. Admin., Inc.*, 422 Mich. 537, 383 N.W. 2d 590, 596 (1986), which held that under Section 500.3109a the health coverage provider has primary responsibility regardless of its coordination provision and the motor vehicle no-fault insurer has secondary responsibility.

The conflict between the Sixth and Seventh Circuits' decisions creates many serious problems. First, their conflicting analysis of ERISA preemption will no doubt create confusion among the lower courts within their circuits and possibly beyond in determining when ERISA preemption applies, and when it does not by reason of the savings clause exception. There is no logical way to reconcile the Sixth Circuit's holding that Section 500.3109a relates to ERISA plans with the Seventh Circuit's holding to the contrary.[3] Because all or most states have laws regulating coordination of benefits and other rules concerning the division of liability among duplicate or multiple insurance coverages, the issue in this case has a nationwide impact.

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[3] The Trustees of the Fund will shortly be filing with this Court a petition for a writ of *certiorari* in the *Indiana Insurance* case.

Moreover, the Sixth Circuit's balancing test can easily be extended to other attempts at state regulation of ERISA plans through state insurance laws. Another serious problem is the invitation to forum-shopping, since the result will depend upon which circuit the plaintiff chooses. In the Sixth Circuit, primary responsibility for the payment of benefits will be imposed on the ERISA plan but, if that same plan files a declaratory judgment action in the Seventh Circuit, its benefit expense may be reduced to fifty percent.[4]

Still greater confusion will obtain if the litigation is brought in a Michigan state court. The Michigan Court of Appeals has construed ERISA preemption in a manner which directly conflicts with the analysis used and results reached by the Sixth and Seventh Circuits. *See State Farm Mut. Auto. Ins. Co. v. C. A. Muer Corp.*, 154 Mich. App. 330, 397 N.W.2d 299 (Mich. Ct. App. 1986). At issue in *C. A. Muer* was whether a self-funded ERISA employee benefit plan, with coordination provisions in its plan document making it excess coverage to certain other insurance coverage, could enforce its COB provision on the basis that Section 500.3109a is preempted by ERISA. In *C. A. Muer*, the Michigan Court of Appeals followed this Court's analysis in the *Metropolitan Life* case and held that ERISA preempted Section 500.3109a to the extent

[4] In affirming the district court's ruling that liability for providing benefits should be divided on a *pro rata* basis, the Seventh Circuit relied upon Indiana Insurance's failure to file a cross-appeal on this issue and to raise arguments against proration before the district court. (Appendix, pp. 7e-8e, *infra.*). The Seventh Circuit also noted that proration was consistent with generally accepted principles from state common law and approved proration as "eminently fair and equitable." (Appendix, p. 6e, *infra.*). The Court warned, however, that ". . . it is by no means clear that we would follow *Northern Group Services* should the question be presented." (Appendix, p. 8e, *infra.*).

it regulated self-funded employee benefit plans and required that the plan's coordination provision imposing primary responsibility on the insurance company be enforced. 397 N.W.2d at 301-303.

As the law stands today, the lower courts are faced with choosing one of three conflicting interpretations of ERISA preemption and how it should be applied to the same state insurance law. This state of confusion can only deteriorate unless this Court issues a writ of *certiorari* in this case.

CONCLUSION

For the reasons discussed herein, this Court should grant this petition to resolve the conflict between this Court's interpretation of Section 514 of ERISA and that of the Sixth Circuit, to reconcile the conflict between the Sixth and Seventh Circuits, to prevent states from authorizing insurance companies and their insureds to set benefit levels and conditions in contravention of the terms of self-funded employee benefit plans and to forestall future adverse effects of such state statutes on such plans.

Respectfully submitted,

ANITA M. D'ARCY *
JAMES L. COGHLAN
COGHLAN, JOYCE, KUKANKOS, URBUT AND D'ARCY

WILLIAM J. NELLIS
Secretary to the Board of Trustees
Central States, Southeast and Southwest Areas Health and Welfare Fund

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Dated: September 16, 1988

* Counsel of Record

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APPENDIX A

[September 16, 1986]

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION – FLINT

HAWKEYE-SECURITY INSURANCE COMPANY,
a foreign insurance company,

Plaintiff,

vs.

TEAMSTERS CENTRAL STATES HEALTH
AND WELFARE FUND,

Defendant.

Civil Action No.: 86-CV-40018-FL

MAGISTRATE'S REPORT AND RECOMMENDATION

Plaintiff filed this action for declaratory judgment and damages on December 5, 1985 in the Circuit Court for the County of Genesee. On January 16, 1986, defendant removed this matter to this Court pursuant to 28 U.S.C. §1441, alleging jurisdiction under 28 U.S.C. §1331 and §1332(a). An amended complaint was filed in this Court by plaintiff on March 12, 1986. That complaint also requested declaratory and monetary relief. The matter is currently before the Court on cross motions for summary judgment. The parties have agreed that there exists no genuine issue of material fact and that the action can be decided as a matter of law. The parties have stipulated to the following facts.

On August 1, 1984, Todd Cannon, his wife Priscilla, and their two sons suffered injuries in an automobile accident. At the time of the accident, the Cannons were insured under a no-fault automobile liability insurance policy issued by plaintiff, and were entitled to medical benefits under that policy. On that date, Mr. Cannon was also a participant in, and his family beneficiaries of, the defendant, Central States, Southeast and Southwest Areas Health and Welfare Fund (The Fund), a self-funded "employee benefit plan" as defined by the Employee Retirement Income Security Act (ERISA). 29 U.S.C. §1001 *et. seq.* As such, they were entitled to receive health and accident benefits in accordance with the terms and conditions of the Fund.

Following the accident, plaintiff paid first party no-fault medical benefits for the Cannons. The defendant Fund also provided medical benefits. The Fund subsequently received a refund from Flint Osteopathic Hospital for overpayment. At the time the motion was filed, plaintiff had paid Fifteen Thousand One Hundred Seventeen Dollars and Thirty-Two Cents ($15,117.32) in medical benefits. Defendant has disbursed One Thousand Five Hundred and Sixty-Eight Dollars and Ninety Cents ($1,568.90).

As noted, plaintiff has filed this action for reimbursement, as well as for declaratory relief. It claims that pursuant to the coordination of benefits provision contained in the policy, as mandated by M.C.L.A. 500.3109(a), it is, as the no-fault insurance carrier, secondarily liable any other coverage which the insured might have. Thus, due to the Cannons' election to coordinate benefits under the statute, plaintiff claims that defendant is primarily liable to pay for the Cannons' medical expenses.

The Fund also has a coordination of benefits provision which coordinates benefits with other plans, including those providing no-fault automobile coverage. The Fund's benefit plan provides that any other plan shall have primary responsibility for providing benefits and that this provision shall prevail over any state or local law. Defendant claims that pursuant to this provision, the plaintiff is primarily liable. Moreover, the Fund claims that MCLA

500.3109(a) is preempted by ERISA and has no force and effect with respect to it.

There is no question but that the Fund is governed by the provisions of ERISA. 29 U.S.C. §1001 *et. seq.* Moreover, ERISA contains a provision which, subject to certain exceptions, preempts state law. That provision, Section 514(a), 29 U.S.C. §1144(a), states:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

The exception referred to above is announced in Section 514(b)(2)(A), 29 U.S.C. §1144(b)(2)(A), the so-called "savings" clause:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

This broad exception is limited, however, by what has been called the "deemer" clause. That provision, §514(b)(2)(B), 29 U.S.C. §1144(b)(2)(B) provides:

> Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

The interpretation and interrelationship of these provisions was recently considered by the Supreme Court in *Metro-*

politan Life Insurance Company v. Massachusetts, ____ U.S. ____, 105 S.Ct. 2380 (1985). In that case, the insurance company argued that a Massachusetts statute, which mandated that all health insurance policies provide minimum mental health benefits, was preempted by §514(a) of ERISA in those cases where the policies were *purchased* by federally-regulated health care plans. The State, on the other hand, contended that its statute was one which regulated insurance within the meaning of the "savings" clause, §514(b)(2)(A) and, therefore, was not preempted by ERISA.

The Court found that the statute in question, through its indirect effect on all insured benefit plans, "related to" pension plans governed by ERISA, within the meaning of the statute, and consequently was within the scope of the preemption provision of §514(a), *id.*, 105 S.Ct. at 2389. However, the Court recognized that by enacting the savings clause, Congress intended to permit the states to regulate insurance contracts, matters traditionally subject to regulation by the state. The Court noted, however, that the state's power to regulate insurance was limited by §514(b)(2)(B), 29 U.S.C. §1144(b)(2)(B), the "deemer clause", which prohibits an employee benefit plan from being considered an insurance company for purposes of §514(b)(2)(A). The Court concluded that since the Massachusetts statute regulated insurance *contracts*, and not *benefit plans*, it was saved from preemption. In doing so, the Court recognized a difference between insured and uninsured benefit plans, a distinction which is determinative of the issue presented in this case.

> We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter. We also are aware that appellants' construction of the statute would eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance. Such

> disuniformities, however, are the inevitable result of the congressional decision to "save" local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress.

Id. at 2392.

Thus, to the extent that a state law attempts to regulate self-insured benefit plans governed by ERISA, §514(a), 29 U.S.C. §1114(a) preempts that law, since such a plan cannot be "deemed" to be an insurance company or other insurer pursuant to §514(b)(2)(B), 29 U.S.C. §1114(b)(2)(B). As the Fund is self-insured, ERISA preempts M.C.L.A. 600.5109(a) to the extent that the statute purports to regulate the plan.

Plaintiff argues that Michigan statute does not "relate to" employee benefit plans, but only to no-fault automobile insurance, and therefore is not within the preemption provisions of ERISA. This argument ignores the Supreme Court's decisions in both *Metropolitan Life* and *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983). In *Shaw*, the Court held that a New York statute which required employers to pay for pregnancy-related disability benefits was preempted by ERISA. In doing so, the Court concluded that a law "relates to" an employee benefit plan if it has a connection with or reference to such a plan. *Id.* at 96-97. The Court went on to note that a state law which would require an employer to pay specific benefits clearly "relates to" a plan. *Id.* at 97. As the Court stated:

> To interpret §514(a) to preempt only state laws specifically designed to affect employee benefit plans would be to ignore the remainder of §514(a).

Id. at 98.

In this case, it is clear that MCLA 500.3109(a) "relates to" the defendant employee benefit plan. The mere fact that the state statute would require the plan to assume primary responsibility for payment of medical benefits for injuries arising out of an automobile accident, in contravention of its own terms, comes within the definition articulated in *Shaw*.

Plaintiff's reliance on *Employers Ass'n. of New Jersey v. State of New Jersey*, 601 F.Supp. 232 (D.N.J. 1985), *aff'd.* 774 F.2d 1151 (3rd Cir. 1986), is similarly misplaced. In that case, the Court held that a no-fault automobile statutory scheme in New Jersey, which had the effect of coordinating benefits to make any other health benefit coverage primarily responsible for the payment of health benefits, was not preempted by ERISA. This finding was predicated on the conclusion that the "savings clause" precluded preemption. The opinion is somewhat confusing in that the plaintiff was an employers association and there was no explicit statement of whether the health benefit plan was self-insured or covered by insurers. However, in describing the effect of the New Jersey statute, the Court stated:

> the New Jersey law . . . by its terms regulates insurance. *It affects only the potential cost of purchasing comparable employee benefits through private insurance carriers* and then only if the insurers chose to raise their premiums due to an increase in personal injury claims.

Id. at 240 (emphasis added).

Thus, contrary to plaintiff's assertions, the Court's opinion was predicated on the conclusion that the New Jersey law would only regulate health benefit policies purchased from private insurance carriers. The Court did not consider whether the statute would be effective with regard to self-insured welfare benefit plans. That decision is therefore inapplicable to this case.

The issue presented in this case is not novel. As noted by the parties, two judges in this district have already concluded that M.C.L.A. 500.5109(a) is preempted by ERISA to the extent that it purports to regulate self-insured welfare benefits plans. *See Northern Group Services, Inc. v. State Farm Mutual Automobile Ins.*, No. 85-75383-DT (E.D.Mich. 1986) [Judge Taylor]; *ACIA v. Pipeline Industry Benefit Plan*, No. 85-70415-DT (E.D.Mich. 1985) [Judge Cook]. An identical conclusion was reached by the Court

in *Kilmer v. Central Counties Bank*, 623 F.Supp. 994 (W.D.Pa. 1985) [ERISA preempts Pennsylvania no-fault automobile insurance law to the extent it purports to regulate self-insured welfare benefit plans]. The distinction between insured and self-insured plans, for the purposes of ERISA preemption of state law, has been recognized by this Circuit in the context of mandatory health care benefits. *See Michigan United Food and Commercial Works v. Baerwaldt*, 767 F.2d 308, 312-13 (6th Cir. 1985). Similarly, in *Children's Hospital v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985), the Court found that a Louisiana statute, which mandated a particular level of mental health benefits, was preempted by ERISA with respect to a self-insured benefit plan.

There exists no basis to reach a differing conclusion in this case. To the extent that M.C.L.A. 600.5109(a) purports to regulate the self-insured welfare benefit plan in this case, it is preempted by ERISA. Accordingly, I respectfully recommend that defendant's motion for summary judgment be granted and that judgment be entered for the defendant.

Pursuant to Rule 72(b) of the Federal Rules of Civil Procedure, parties are hereby notified that within ten days after being served with a copy of this recommendation they may serve and file specific, written objections to the proposed findings and recommendations. Further, either party may respond to another party's objections within ten days after being served with a copy thereof.

/s/ MARC L. GOLDMAN
United States Magistrate

Dated: September 16, 1986

APPENDIX B

[January 23, 1987]

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

HAWKEYE-SECURITY INSURANCE COMPANY,

Plaintiff,

v.

TEAMSTERS CENTRAL STATES HEALTH & WELFARE FUND,

Defendant.

Civil Action No.: 86-40018

ORDER ACCEPTING MAGISTRATE'S REPORT AND RECOMMENDATION

A hearing having been held on January 23, 1987, on objections to the Magistrate's Report and Recommendation filed with this Court on September 16, 1986;

IT IS HEREBY ORDERED that the Magistrate's Report and Recommendation be ACCEPTED and defendant's motion for summary judgment is GRANTED.

IT IS SO ORDERED.

/s/ STEWART A. NEWBLATT
United States District Judge

APPENDIX C

[January 23, 1987]

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN -
SOUTHERN DIVISION

HAWKEYE-SECURITY INSURANCE COMPANY,

Plaintiff,

v.

TEAMSTERS CENTRAL STATES HEALTH & WELFARE FUND,

Defendant.

Civil Action No.: 86-40018

JUDGMENT

This Court having entered an Order Accepting the Report and Recommendation of the Magistrate as the findings and conclusions of this Court;

It Is Ordered and Adjudged that judgment be entered for the defendant, that the plaintiff take nothing and that this action be dismissed.

Dated: January 23, 1987

ROBERT A. MOSSING,
CLERK

BY: /s/ RUTH A. JOZWIAK
Deputy Clerk

APPENDIX D

No. 87-1201

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

HAWKEYE-SECURITY INSURANCE COMPANY,
Plaintiff-Appellant,

v.

TEAMSTERS CENTRAL STATES HEALTH & WELFARE FUND,
Defendant-Appellee.

On Appeal from the United States District Court
for the Eastern District of Michigan.

Decided and Filed June 21, 1988

BEFORE: NELSON and BOGGS, Circuit Judges, and EDWARDS, Senior Circuit Judge.

PER CURIAM. In rendering summary judgment for the defendant in this case, the district court held that Mich. Comp. Laws §500.3109(a), a provision of Michigan's No-Fault Automobile Insurance Act, was preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§1001-1461. We subsequently held that §500.3109(a) has not been so preempted. *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 56 U.S.L.W. 3786 (5/17/88). That decision is dispositive of this appeal. Accordingly, the judgment of the district court is REVERSED, and the case is REMANDED with instructions to enter judgment for the plaintiff. *See Federal Kemper Ins. Co. v. Health Ins. Administration*, 424 Mich. 537, 383 N.W.2d 590, 596 (1986).

APPENDIX E

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 87-2437

MARION M. WINSTEAD, et al.,

Plaintiffs-Appellants,

v.

INDIANA INSURANCE COMPANY,
a foreign corporation,

Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 86 C 3414—**Susan Getzendanner,** *Judge.*

ARGUED MARCH 30, 1988—DECIDED AUGUST 22, 1988

Before CUDAHY, RIPPLE, and MANION, *Circuit Judges.*

CUDAHY, *Circuit Judge.* The plaintiffs-appellants are trustees of the Central States, Southeast and Southwest Areas Health and Welfare Fund (the "Fund"), a multi-employer, self-insuring trust fund governed by the Employment Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* The defendant-appellee, Indiana Insurance, is an insurance company authorized to sell its policies in the State of Michigan. On August 31, 1985, Renee Crampton, insured by both the Fund and Indiana Insurance, was injured in an automobile

accident in Jackson County, Michigan. As a result, Crampton required medical treatment and hospitalization; the costs of these services were paid in good faith by the Fund. Subsequently, the Fund filed this lawsuit to have Indiana Insurance declared primarily liable for Crampton's coverage and to obtain reimbursement for those amounts already paid on Crampton's behalf. The parties cross-moved for summary judgment and the district court held that liability should be apportioned *pro rata*. We affirm.

I.

At the time of her accident, Crampton was insured by the Fund pursuant to a collective bargaining agreement covering her husband and funded by his employer. She was also covered by a no-fault auto insurance policy mandated by Michigan law and underwritten by Indiana Insurance. Both policies covered the medical expenses resulting from the accident and both contained a "coordination of benefits" provision providing that any "other" insurance plan covering the insured would be primarily liable for any medical or other health-related expenses she might incur.[1]

The Fund disclaims liability based upon the priority of coverage clause in its plan document. That provision reads, in pertinent part:

> Section 11.05 *PRIORITY OF COVERAGE WHERE COVERED INDIVIDUAL COVERED BY AN OTHER PLAN AS DEFINED IN SECTION 1.42(f)*
>
> (a) An Other Plan, as defined in Section 1.42(f), shall have primary responsibility for providing bene-

[1] Although Michigan law required Crampton to obtain no-fault coverage, she remained free to choose between a lower premium policy containing a "coordination of benefits" provision and a policy with slightly higher premiums without such a provision. *See infra* p. 5. The latter coverage is more expensive because it permits an insured to recover the entire amount of loss from the insurer, not just what is left unpaid by any other coverage considered "primary."

> fits. The above designation of an Other Plan as defined in Section 1.42(f) as primary shall prevail over any state or local law or regulation or provision in such Other Plan inconsistent therewith or contrary thereto.

In turn, Section 1.42(f) of the Fund plan defines an "Other Plan" to include any:

> Automobile, motorcycle or other motor vehicle insurance coverage authorized by law to provide benefits to or for a Covered Individual for bodily and psychological injury, including but not limited to, related hospital, surgical, dental and other medical expenses, which expenses are also covered by this Plan, and which insurance coverage was issued in conformity with "no-fault" type or "personal injury protection" type laws or other similar state or local laws or regulations.

On the basis of these provisions, the Fund moved for summary judgment, arguing that in the circumstances of this case federal ERISA law should be held to preempt state law. Accordingly, the Fund's "other insurance" clause would render it the insurer of last resort, thus limiting its liability to only those expenses left uncovered by Crampton's other insurance policies.

Indiana Insurance also moved for summary judgment, based upon the "other insurance" clause in its no-fault auto insurance contract. That provision states that under policies such as Crampton's (denominated "secondary med/wage") medical expenses are not covered "to the extent similar benefits are paid or payable under any other insurance, service, benefit or reimbursement plan . . . ." Indiana Insurance argued that, in the absence of controlling federal case law, when an "other insurance" clause of a non-ERISA automobile policy providing medical benefits conflicts with a similar clause in an ERISA insurance policy, federal courts should look to state law for the appropriate rule of decision. Predictably, Indiana Insurance asserted that in these circumstances Michigan law—the

law of the state where its policy was written and where the insured was domiciled—should govern. Moreover, the company cited a recent Michigan Supreme Court case, *Federal Kemper Insurance Co. v. Health Insurance Administration, Inc.*, 424 Mich. 537, 383 N.W.2d 590 (1986), which held that in the event "other insurance" provisions conflict, the health benefits insurer (here, the Fund) is to be deemed primarily liable to provide coverage.

The district court initially agreed with the Fund, holding that to the extent Michigan law would have the effect of imposing higher benefit levels than the Fund would otherwise provide, ERISA preempts Michigan law. The court went on, however, to reject as "unconvincing" the Fund's argument that, *a fortiori*, the contested provision of Crampton's insurance contract with Indiana Insurance was encompassed within the scope of ERISA preemption and thereby automatically rendered unenforceable. Instead, faced with two equally viable but conflicting "other insurance" clauses, the court declared them to be mutually repugnant and, guided by *federal* common law, held both insurers liable on a *pro rata* basis.

II.

On appeal, the Fund once again argues that federal ERISA law preempts the Indiana Insurance policy. To the extent that the latter's provisions conflict with the terms of the Fund's coverage, the terms and conditions of the Fund policy must be enforced. However, the district court rejected the Fund's broad construction of ERISA preemption, explaining that by its own terms ERISA was designed only to supersede "any and all *State laws* insofar as they may now or hereafter relate to any employee benefit plan." (Emphasis supplied). *See* 29 U.S.C. § 1144(a). *See also Fort Halifax Packing Co., Inc. v. Coyne*, 107 S. Ct. 2211, 2217 (1987) (although state laws mandating benefit payments "relate to" employee benefits *plans* and are thus preempted, the mere fact that a state law pertains to a type of employee *benefit* does not re-

quire that the law therefore must be preempted). We agree with the conclusion of the district court that the relevant provision of the Indiana Insurance policy is not rendered void merely as the result of Crampton's concurrent ERISA coverage.

The decision to purchase insurance coverage in addition to ERISA coverage featuring an "other insurance" clause is a decision which undoubtedly affects the Fund's potential liability for benefits payments and is, therefore, a decision that "relates to" an ERISA benefits plan. *Id.* Crampton's decision to so proceed, however, was a private contractual matter between her and Indiana Insurance; it was in no way compelled by state law. As the district court properly concluded, nothing in ERISA suggests that individuals are barred from acting as Crampton did in insuring themselves. In fact, a state's ability to facilitate such private choice has been held by the Supreme Court, albeit implicitly, *not* to be preempted by ERISA. *See Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724, 756-58 (1985). Michigan law requires nothing more of companies licensed to underwrite insurance within the state than that they *offer* reduced premium policies with coordination of benefits clauses to those insureds already covered by other health and accident coverage. Mich. Comp. Laws § 500.3109a. The choice to avail oneself of such a policy is strictly a personal one, and thus a matter that ERISA did not intend to preempt.

Having excluded the possibility that ERISA preemption causes the Fund's coordination of benefits provision to supersede the Indiana Insurance policy, the district court turned to federal common law to determine which insurer qualified as Crampton's primary coverage provider.[2] The court's analysis followed the approach taken

[2] Although the district court relied upon what it termed "federal common law," the court was in reality fashioning federal common law from what has evolved generally in the states as the common law in similar circumstances.

by the Third Circuit in the only other case in which a federal court arguably reached the issue of apportioning liability between an ERISA policy and a non-ERISA policy containing incompatible "other insurance" provisions.[3] In *Northeast Dept. ILGWU v. Teamsters Local 229*, 764 F.2d 147 (3d Cir. 1985), the Third Circuit was presented with two different types of conflicting "other insurance" clauses, one of which the court held unenforceable as a matter of law. Thus, *Northeast Dept. ILGWU* never actually addressed the issue of how to choose between two truly conflicting and equally viable "other insurance" clauses. A footnote to the decision, however, indicates that "other courts faced with incompatible 'other insurance' clauses have frequently declared the clauses to be 'mutually repugnant' and have held both insurers primarily liable for the insured's loss on a pro-rata basis. *See* 8A Appleman, Insurance Law and Practice § 4910, at 477." *Northeast Dept. ILGWU*, 764 F.2d at 161 n.13. *See also* 16 *Couch on Insurance* §§ 62:79-62:81 (2d ed.). Application by the district court in this case of such a solomonic apportionment of liability is not only in keeping with generally accepted notions derived from state common law, *see* Appleman and Couch, *supra*, but seems eminently fair and equitable.

An additional issue remains to be resolved. In its brief on appeal, Indiana Insurance asks us to reverse that part of the district court's determination finding it liable for half of Crampton's benefits. As authority for its request, Indiana Insurance cites *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied* 108 S. Ct. 1754 (1988), which held that ERISA did not preempt Michigan's no-fault insurance scheme and

[3] While other federal courts have been presented with the general question whether and under what circumstances a coordination of benefits clause in an ERISA policy nullifies a similar clause in a non-ERISA policy, our research suggests that no court has actually decided how to apportion liability between two such policies when both their respective "other insurance" provisions are found to be viable and enforceable.

its attendant coordination of benefits component.[4] Fortunately, we need not parse the confusing and, at times, self-contradictory clauses of ERISA[5] nor engage in an analysis of the Sixth Circuit's decision in *Northern Group Services* because Indiana Insurance may not raise the preemption issue on appeal.

Indiana Insurance failed to file a cross-appeal here. While it is well-settled that an appellee need not file a cross-appeal in order to argue different grounds to support an affirmance, *see Washington v. Lane*, 840 F.2d 443, 445-46 (7th Cir. 1988), the filing of a cross-appeal *is* required where an appellee seeks alteration of a judgment

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[4] In *Northern Group Services*, the Sixth Circuit analyzed the Michigan no-fault law in terms of ERISA's preemption provisions and concluded that the federal statute did not preempt the state law. First, the court held that to the extent the Michigan statute required coordination of benefits clauses, it was preempted because such clauses "related to" ERISA benefits plans. *See* 29 U.S.C. § 1144(a). Next, the court found that because the Michigan statute could be construed to "regulate insurance" it was within ERISA's "savings clause," which provides (with an exception created by the "deemer clause") that preemption does not apply to state laws which merely "regulate" insurance. *See* 29 U.S.C. § 1144(b)(2)(A). Finally, the court found that ERISA's "deemer clause," providing that employee benefit plans are *not* to be "deemed" to be insurance companies for purposes of any state law purporting to regulate insurers or insurance, *see* 29 U.S.C. § 1144(b)(2)(B), did not operate to preempt Michigan's statute. The court held that the "deemer" clause could only override the "savings" clause if there were some ERISA-related interest in federal uniformity outweighing the interest articulated by Congress in the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, in favor of state regulation of insurance. Because the Sixth Circuit could discern no federal interest in a unified federal common law to govern conflicting "other insurance" clauses, *Northern Group Services* held that the "deemer" clause was inapplicable to the Michigan statute and thus the statute remained saved by the "savings" clause.

[5] The Supreme Court has observed that ERISA's preemption provisions "are not a model of legislative drafting." *Metropolitan Life Insurance Co.*, 471 U.S. at 739; *see also MacLean v. Ford Motor Co.*, 831 F.2d 723, 726 (7th Cir. 1987).

rendered in whole or in part in its favor. *Jordan v. Duff and Phelps, Inc.*, 815 F.2d 429, 439 (7th Cir. 1987). Consequently, Indiana Insurance is not entitled to relief in this court from that portion of the district court's judgment finding it partially liable for Crampton's benefits.

Similarly, whether or not the Sixth Circuit's preemption analysis in *Northern Group Services* is correct, Indiana Insurance has waived arguments derived from that analysis for purposes of this appeal by failing to advance them in the district court. *See e.g., Johnson v. Artim Transportation System, Inc.*, 826 F.2d 538, 547 (7th Cir. 1987). In the district court Indiana Insurance argued that state (Michigan) law ought to provide the rule of decision in this case *not* because ERISA did not preempt state law but because there was no applicable federal common law on which the court could rely. Indiana Insurance now contends that it felt constrained from contesting the preemption issue in the district court for fear that it might thereby incur Rule 11 sanctions; this seems a weak explanation. It is true that at the time the Fund brought this lawsuit federal case law (all of it from district courts) addressing ERISA preemption of non-ERISA "other insurance" clauses was apparently unanimously adverse to Indiana Insurance. But none of these cases, all from district courts outside the Seventh Circuit, could be said to control the decision of a district court in this case. And also, there were no decisions on point in the Seventh Circuit when this case was before the district court. It is most unlikely that a district court faced with an issue of first impression in its own circuit would impose Rule 11 sanctions on a party who, while recognizing adverse precedent elsewhere, nevertheless urged the court to find differently. Indiana Insurance's waiver of the preemption issue below thus ought not to be excused. In any event, it is by no means clear that we would follow *Northern Group Services* should the question be presented.

III.

In conclusion, we hold that the district court correctly found: (i) that ERISA does not preempt and thereby did not render unenforceable the "other insurance" provision contained in Renee Crampton's no-fault policy; (ii) that the Fund's and Indiana Insurance's coordination of benefits clauses should be declared mutually repugnant; and (iii) that the contested liability be apportioned *pro rata*.

AFFIRMED.

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

APPENDIX F

I.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

29 U.S.C. Section 514

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * * * *

(8) Subsection (a) of this section shall not apply to any State law mandating that an employee benefit plan not include any provision which has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan, because that individual is provided, or is eligible for, benefits or services pursuant to a plan under title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.], to the extent such law is necessary for the State to be eligible to receive reimbursement under title XIX of that Act.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

29 U.S.C. Section 3

§ 3 Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. Section 402

§ 1102. Establishment of plan

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

29 U.S.C. Section 403

§ 1103. Establishment of trust

(a) Benefit plan assets to be held in trust; authority of trustees

Except as provided in subsection (b) of this section, all assets of an employee benefit plan shall be held in trust by one or more trustees. Such trustee or trustees shall

be either named in the trust instrument or in the plan instrument described in section 1102(a) of this title or appointed by a person who is a named fiduciary, and upon acceptance of being named or appointed, the trustee or trustees shall have exclusive authority and discretion to manage and control the assets of the plan, except to the extent that—

(1) the plan expressly provides that the trustee or trustees are subject to the direction of a named fiduciary who is not a trustee, in which case the trustees shall be subject to proper directions of such fiduciary which are made in accordance with the terms of the plan and which are not contrary to this chapter, or

(2) authority to manage, acquire, or dispose of assets of the plan is delegated to one or more investment managers pursuant to section 1102(c)(3) of this title.

29 U.S.C. Section 404

§ 1104. Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

* * * * *

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter or subchapter III of this chapter.

II.

MICHIGAN NO-FAULT INSURANCE ACT

Mich. Comp. Law Ann. § 500.3109a

500.3109a. Deductibles and exclusions relating to other health and accident coverage

An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The deductibles and exclusions required to be offered by this section shall be subject to prior approval by the commissioner and shall apply only to benefits payable to the person named in the policy, the spouse of the insured and any relative of either domiciled in the same household.

Mich. Comp. Law Ann. § 500.3101

500.3101. Security for payment of benefits under personal and property protection and residual liability insurance; definitions

(1) The owner or registrant of a motor vehicle required to be registered in this state shall maintain security for payment of benefits under personal protection insurance, property protection insurance, and residual liability insurance. Security shall only be required to be in effect during the period the motor vehicle is driven or moved upon a highway. Notwithstanding any other provision in this act, an insurer that has issued an automobile insurance policy on a motor vehicle that is not driven or moved upon a highway may allow the insured owner or registrant of the motor vehicle to delete a portion of the coverages under the policy and maintain the comprehensive coverage portion of the policy in effect.

Mich. Comp. Law Ann. § 500.3107

500.3107. Personal protection insurance benefits, allowable expenses, work loss

Personal protection insurance benefits are payable for the following:

(a) Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery or rehabilitation. Allowable expenses within personal protection insurance coverage shall not include charges for a hospital room in excess of a reasonable and customary charge for semiprivate accommodations except when the injured person requires special or intensive care, or charges for funeral and burial expenses in excess of $1,000.00.

III.

MICHIGAN INSURANCE CODE OF 1956

Mich. Comp. Law Ann. § 500.2236

500.2236. Basic insurance policy and annuity contract forms Filing, approval, size of type

(1) No basic insurance policy form or annuity contract form shall be issued or delivered to any person in this state, and no application form where a written application is required and is to be made a part of such policy or contract, no printed rider or indorsement form or form of renewal certificate, and no group certificate in connection with any such policy or contract, shall be issued or delivered to any person in this state, until a copy of the form thereof is filed with the department of insurance and approved by the commissioner as conforming with the requirements of this code and not inconsistent with the law. Failure of the commissioner to act within 30 days after submittal shall constitute approval. All such forms, except policies of disability insurance as defined in section 3400[1] shall be plainly printed with type size not less than 8-point

unless the commissioner determines that such portions of any such form printed with type less than 8-point is not deceptive or misleading.

* * * * *

Application of section

(6) The filing requirements of this section shall not apply to:

(a) Insurance against loss of or damage to:

(i) Imports, exports, or domestic shipments.

(ii) Bridges, tunnels, or other instrumentalities of transportation and communication.

(iii) Aircraft and attached equipment.

(iv) Vessels and watercraft under construction or owned by or used in a business or having a straight-line hull length of more than 24 feet.

(b) Insurance against loss resulting from liability, other than worker's compensation or employers' liability arising out of the ownership, maintenance, or use of:

(i) Imports, exports, or domestic shipments.

(ii) Aircraft and attached equipment.

(iii) Vessels and watercraft under construction or owned by or used in a business or having a straight-line hull length of more than 24 feet.

(c) Surety bonds other than fidelity bonds.

(d) Policies, riders, indorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject, or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder or certificate holder. Beginning September 1, 1986, the commissioner by order may exempt from the filing requirements of this section and sections 2242, 3606, and 4430[4] for so long as he or she deems proper

any insurance document or form or type thereof, except that portion of the document or form that establishes a relationship between group disability insurance and personal protection insurance benefits subject to exclusions or deductibles pursuant to section 3109a,[5] as specified in the order to which this section practicably may not be applied, or the filing and approval of which are deemed unnecessary for the protection of the public. Insurance documents or forms providing medical payments or income replacement benefits, except that portion of the document or form that establishes a relationship between group disability insurance and personal protection insurance benefits subject to exclusions or deductibles pursuant to section 3109a, exempt by order of the commissioner from the filing requirements of this section and sections 2242 and 3606 are deemed approved by the commissioner for purposes of section 3430.[6]

Supreme Court, U.S.
FILED
DEC 9 1988
JOSEPH F. SPANIOL, JR.
CLERK

(2)

No. 88-487

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1988

CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND,
Petitioner,

v.

HAWKEYE-SECURITY INSURANCE COMPANY
Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT
BRIEF IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI

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9P

QUESTIONS PRESENTED

1. Should this Court grant certiorari on the issue involved in case-at-bar when the Court has previously considered whether to grant certiorari on the same issue and denied the petition for writ of certiorari? *Northern Group Services, Inc.,* 833 F2d 85 (6th Cir. 1987), cert. denied, ___ U.S. ___, 108 S. Ct. 1754 (1988)

2. Should this Court grant certiorari on an ERISA pre-emption claim against MCLA 500.3109a of Michigan's No-Fault Automobile Insurance Act where there is no conflict between the United States Courts of Appeal for Sixth and Seventh Circuits as to whether the statute is pre-empted by ERISA?

3. Should this Court grant certiorari on an ERISA pre-emption claim against MCLA 500.3109a where there is no conflict between the decisions of this Court and the decisions of the Sixth Circuit regarding the ERISA pre-emption issue in question?

STATEMENT OF CORPORATE AFFILIATES, PARENTS, AND NOT-WHOLLY-OWNED SUBSIDIARIES

HAWKEYE-SECURITY INSURANCE COMPANY

Parent: USLICO Corporation

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SUMMARY OF ARGUMENT

For several reasons, the Court should not accept this case for review.

First, the Court has already considered whether to grant a petition for writ of certiorari on the issue involved in the case-at-bar and has denied the petition. *Northern Group Services, Inc. vs. Auto-Owners Ins. Co.,* 833 F. 2d 85 (6th Cir. 1987), cert denied ____ U.S. ____, 108 S. Ct. 1754 (1988).

Second, there is no conflict between the United States Court of Appeals for the Sixth and Seventh Circuits because both Circuits have rejected petitioners sole argument that Section 500.3109a of Michigan's No-Fault Act Automobile Insurance is pre-empted by ERISA. Although the respective circuits have used a different analysis to find the state insurance law is not pre-empted by ERISA, neither circuit has upheld petitioner's claim that ERISA totally pre-empts operation of the state insurance law.

Third, there is no conflict between the decisions of the Sixth Circuit Court of Appeals and this Court regarding ERISA pre-emption of state insurance law regulation of self-funded employee benefit plans. In fact, the decisions of this Court recognize that when a state insurance law is at issue, the presumption is against pre-emption.

ARGUMENT

A. THIS COURT HAS PREVIOUSLY CONSIDERED WHETHER TO GRANT CERTIORARI ON THE SAME ISSUE INVOLVED IN THE CASE-AT-BAR AND HAS DENIED THE PETITION FOR WRIT OF CERTIORARI.

In *Northern Group* the United States Sixth Circuit Court of Appeals held that MCLA 500.3109a of Michigan's No-Fault Automobile Insurance Act was not pre-empted by ERISA. Relying on *Northern Group* another panel of the Sixth Circuit ruled

that decision was dispositive of the issue involved in the case-at-bar. This Court has recently denied certiorari in *Northern Group* and respondent requests a denial of the petition for writ of certiorari in the case-at-bar for the same reasons the petition was denied in *Northern Group.*

B. THERE IS NO CONFLICT BETWEEN THE UNITED STATES COURT OF APPEALS FOR THE SIXTH AND SEVENTH CIRCUITS ON THE QUESTION WHETHER ERISA PRE-EMPTS SECTION 500.3109a OF THE MICHIGAN NO-FAULT AUTOMOBILE INSURANCE ACT.

Petitioner contends the Sixth Circuit decisions in the case-at-bar and *Northern Group* are in conflict with the Seventh Circuit in *Winstead v. Indiana Ins. Co.,* App No. 87-2437, slip op. (7th Cir. August 22, 1988) However, both Circuits held MCLA 500.3109a was not pre-empted by ERISA. Although the respective circuits used a different analysis to find there was no pre-emption, the difference in analysis does not mean the respective circuits are in conflict. The insurance company in *Winstead* failed to raise on appeal the arguments raised on appeal by the insurance companies in *Northern Group* and the case-at-bar. In fact, the Seventh Circuit declined to engage in an analysis of the *Northern Group* decision and stated the insurance company had waived any arguments derived from that analysis for purposes of its appeal from the district court. (See Appendix E of Petition, pp. 6e-8e).

Thus, in light of the fact that the Seventh Circuit did not even consider the analysis of the Sixth Circuit in *Northern Group*, petitioners statement that the decisions of the respective circuits are in conflict is in error. The decisions of the respective circuits have both rejected petitioners claim that ERISA totally pre-empts and renders unenforceable the coordination of benefits provision contained in a Michigan no-fault automobile insurance policy by virtue of MCLA 500.3109a.

C. THERE IS NO CONFLICT BETWEEN THE DECISIONS OF THIS COURT AND THOSE OF THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT REGARDING THE ERISA PREEMPTION ISSUE IN QUESTION.

Petitioner contends the Sixth Circuit decisions in the case-at-bar and *Northern Group* directly conflict with several of this Court's decisions which construe Section 514 of ERISA, 29 U.S.C. Section 1144. However, the Sixth Circuit decisions are not in conflict, either directly or indirectly, with any of the Court's decisions cited by petitioner. Specifically, the Sixth Circuit decisions do not conflict with *Metropolitan Life Ins. Co. vs. Massachusetts,* 471 U.S. 724; 105 S. Ct. 2380; 85 L. Ed. 2d 728 (1985), in which this Court held that when a state insurance law is at issue, "[t]he presumption is against pre-emption." 471 U.S. at 741. As the Sixth Circuit noted, this Court did not render a definitive interpretation of the deemer clause in *Metropolitan Life. Northern Group* at 833 F. 2d 90-91 (1987). Because *Metropolitan Life* did not reach or involve any issue concerning the deemer clause, the Court's comment about what the deemer clause might mean was obiter dicta. Moreover, as the Sixth Circuit noted:

> Nor is this approach inconsistent with the dicta in *Metropolitan Life* concerning insured versus self-insuring plans. 471 U.S. at 740-41, 747, 105 S. Ct. at 2389-90, 2393. We preserve a distinction between insured and self-insuring plans. Insured plans would be per se "open to indirect regulation." Id. at 747, 105 S. Ct. at 2393. Self-insuring plans would be subject to state regulation only when no independent federal interest in national uniformity exists to inform and guide the creation of federal common law.
>
> Id. at 94-95 (citations omitted).

CONCLUSION AND RELIEF

The petition should be denied because this case is not appropriate for Supreme Court review. The Court has previously considered whether to grant certiorari on the same issue involved in the case-at-bar and denied the petition. There is no conflict among the circuits as to whether ERISA pre-empts state coordination of benefits rules from being applied to uninsured plans. Finally, the Sixth Circuit decisions regarding the ERISA pre-emption issue involved in the case-at-bar are not in any way in conflict with the decisions of this Court.

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